CHAPTER 1
SECTION 7.1

SPECIAL AUTHORIZATION REQUIREMENTS

ISSUE DATE: August 4, 1988
AUTHORITY: 32 CFR 199.4(a)(11) and 32 CFR 199.5(a)(4)

I. POLICY

Unless otherwise specifically excepted, the adjudication of the following types of care is subject to the following authorization requirements:

A. Adjunctive dental care must be preauthorized.

B. Program for Persons with Disabilities (formerly known as Program for the Handicapped) benefit must be authorized by the appropriate contractor.

C. Effective October 1, 1991, preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be cost-shared (includes Residential Treatment Center care and alcoholism detoxification and rehabilitation). Effective September 29, 1993, preadmission and continued stay authorization is also required for all care in a partial hospitalization program.

D. Effective November 18, 1991, psychoanalysis must be preauthorized.

E. The Executive Director, TMA, or designee, may require preauthorization of admission to inpatient facilities.

F. Organ and stem cell transplants are required to be preauthorized. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in this Policy Manual, or until the approved transplant occurs.

G. Each TRICARE Regional Managed Care Support (MCS) contractor may require additional care authorizations not identified in this section. Such authorization requirements may differ between regions. Beneficiaries and providers are responsible for contacting their contractor for a listing of additional regional authorization requirements.

NOTE: When a beneficiary has "other insurance" that provides primary coverage, preauthorization requirements in paragraph I.G. will not apply. Any medically necessary reviews the MCS contractor believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis. The conditions for applying this exception are the same as applied to the NAS exception in Chapter 1, Section 6.1, paragraph III.A.

H. Provider payments are reduced for the failure to comply with the preauthorization requirements for certain types of care. See the TRICARE Reimbursement Manual, Chapter 1, Section 28.

I. The first 8 outpatient mental health visits per beneficiary in a fiscal year do not require PCM or Health Care Finder referral and do not require preauthorization. Mental health visits exceeding 8 in a fiscal year require authorization, but do not require a referral. The authorization of outpatient mental health care after the first 8 visits (visits 9 forward) shall be in accordance with the MCSC's best practices. This does not apply to mental health care received by active duty personnel. Mental health care for active duty personnel requires preauthorization.

NOTE: Active duty service members require preauthorization before receiving mental health services. The contractor shall comply with the provisions of the TRICARE Operations Manual, Chapters 17 and 18 when processing requests for service for active duty personnel.

- END -